City of Fresno
Medical Provider Network
Employee Physician Pre-Designation Form

If I am injured on the job, I request to be treated by my personal physician who has treated me before and has my medical treatment records.

Employee Information

Employee's Name (please print) | *Department/Division*

Employee's Date of Birth | *Employee's Date of Hire*

I understand that my physician must agree to act as my Primary Treating Provider under my employer's worker's compensation program for my work-related injury. In the event the above named physician is not appropriate to treat my work-related injury or does not agree to act in this capacity, I will be required to seek care with a MPN physician.

Employee Signature | *Date*

Your Doctor's Information:

Print Physician's Name | *Physician's Federal Tax ID Number*

Physician's Specialty | *Physician's Telephone Number*

Physician's Address

I hereby certify that I am the above named employee's regular physician, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code. I have personally directed the medical treatment of this employee, and I retain this employee's medical records, including his or her medical history. I agree to be pre-designated as this employee's physician in the event of an industrial injury or illness.

Physician Signature | *Date*

(Note to employer: Retain the completed form in employee's personnel file and forward a copy to the TMC MPN Coordinator.)

For questions about the City of Fresno MPN, please contact the Risk Management Division at (559)621-6900 or by e-mail to personnel@fresno.gov